

**SOUTH CAROLINA  
WHITE HOUSE CONFERENCE ON AGING**

**April 25-27, 2005**

**(E)  
Health Care**

**Issue Papers**

**Springs A-C**

# **Prevention and Wellness “Among” Older Americans**

*By*

Cora Plass, LISW, ACSW  
Director of Healthy Aging  
SC Department of Health & Environmental Control  
Columbia, South Carolina

## **Prevention and Wellness Among Older Americans**

Issue: Americans are living longer, and the proportion of older adults in the population is increasing rapidly. By 2030, 70 million Americans or 1 in every 5 will be 65 and older. The trend in South Carolina is consistent with the national trend. In 2000 in South Carolina, there were 485,300 persons aged 65 and older, a number that has increased by 100,000 every decade from 1950 to 1990, and by 90,900 from 1990 to 2000. The over-85 age group is growing at an even more rapid rate. By the year 2025, estimates are that the number of people over 85 in SC will reach 98,609, representing a 96 percent increase from 2000.

The demographic shift toward an older population places increased demands on the public health, medical, and social service systems. Countless older Americans suffer from chronic diseases, the leading causes of death and disability. Chronic diseases can cause years of pain, suffering, and disability, and can lead to extensive medical and long-term care expenditures before ultimately resulting in death. The human and economic impact is enormous. Eighty percent of people 65 and older are living with at least one chronic disease. The average 75 year old has three chronic conditions and takes five prescription medications. Arthritis, the leading cause of disability in the nation, affects nearly 60% of adults aged 65 and older. The diabetes rate for the 65 and older age group in SC is 7-8% higher than for the 45-64 year old age group, and the diabetes death rate for older adults is more than 4 times higher. The death rate from cardiovascular disease, the leading cause of death in SC, is 5 times higher among people 65 and older than among people ages 45-64. For all types of cancer, the rate for adults 65 and older is almost 9 times higher than for younger populations. For prostate, lung, and colon cancer, the difference is even more pronounced. For many diseases and conditions, racial disparities make the burden of chronic disease even greater for African Americans in SC.

Although the risk of chronic disease, disability, and death increases with age, “poor health or disabilities are not inevitable consequences of aging (CDC).” Many older adults suffer needlessly from chronic diseases that can be prevented or delayed. Scientifically proven preventive measures, such as healthy lifestyle behaviors (eating healthy, avoiding tobacco use, and exercising regularly) and clinical preventive services (influenza and pneumonia vaccinations and early detection of disease through screening) can extend life and preserve quality of life. It is never too late to make behavior changes. Simple health promotion practices, such as regular physical activity, can prevent many chronic diseases and make it possible for older adults to remain at home in their own communities. Use of prevention measures would substantially reduce the personal, familial, social, and economic costs of aging and would lead to healthy and productive years of life for the growing population of seniors. Public health and aging professionals should be at the forefront of developing approaches to help older adults put into practice these simple measures to enjoy healthy aging.

**Barriers:** While there is ample evidence of the benefits of prevention strategies, knowledge has not yet been turned into action. Current resources are not adequate to address the population boom of older adults that is facing America. Evidence-based prevention and wellness programs are still not commonplace, especially in rural areas. Programs that do exist often have fees attached, preventing those most in need from participating. Furthermore, public health initiatives targeted toward prevention measures for older adults are limited due to lack of federal and state funding to support such initiatives. The challenge is to develop prevention programs that are accessible to older adults of all races, ethnic backgrounds, and interests.

While there has been some movement toward prevention approaches, for the most part, health care is still based on a traditional fee-for-service treatment approach, rather than a prevention focus. Until the health care system makes dramatic changes in coverage and provides incentives for health care providers to prescribe prevention approaches, access to prevention services will continue to be limited.

Like the health care system, many social service programs focus on treatment, rather than prevention and supportive services, such as respite care for family caregivers. It is not uncommon for individuals and their families to be forced to seek institutionalization because there are no programs to support family caregiving efforts. While social support is a key factor for positive mental health and healthy aging, enhancing support from family and friends and developing social networks are often overlooked in social service programs.

**Solutions:** To address the challenges posed by an aging population, the traditional health care focus of treating disease and extending life, regardless of its quality, must shift to one of preventing disease and disability and improving quality of life. Making healthy aging a reality will require an integrated approach that includes research, education, expanded public health and aging initiatives, improved medical practices, community planning, and social service programs that support aging in place. Additionally, aggressive health communication and outreach efforts are needed to overcome disparities and to make prevention practices widely available and accessible to all population groups 65 and older throughout SC.

Further research is needed to develop scientifically based prevention programs that are accessible to older adults of all races, ethnic backgrounds, and interests. Health policy changes are also needed to support proven prevention measures and to make them widely available. National policy that supports states in expanding health promotion and disease prevention programs is critical, along with designated funding for these programs.

In addition to research and policy change, considerable revisions are needed in the health care delivery system to promote and expand prevention practices among older adults. The use of prevention, screening, and early detection services, along with immunizations against influenza and pneumonia, must be expanded to improve years

and quality of life. Primary and geriatric care practices should routinely include health education and chronic disease prevention counseling, and referral to community resources that prevent institutionalization and support healthy aging in an individual's natural environment. There is already overwhelming evidence that such an approach would save lives and significantly reduce health care costs.

To adequately address the growing aging population, social and environmental issues can not be ignored. Community design and transportation may support or create barriers to healthy behaviors. For example, whether there are sidewalks, whether neighborhoods are safe, or whether public transportation is available to access programs and services are factors that must be considered and incorporated into a comprehensive approach to increase years of healthy living.

The extent and quality of social relationships are critical factors in determining the physical and mental health of older adults. Social service and health programs should develop strategies to strengthen and expand existing natural support networks in the community to promote aging in place and prevent institutionalization. For example, the provision of supportive services for family caregivers would prevent or delay institutionalization in many cases and would result in significant cost savings. Rather than operate in isolation, social service and health programs should collaborate with community design and planning organizations to create an integrated approach for aging in place that fits the needs of the community.

**Recommendations:** Immediate attention is required at the national level to make state prevention programs a reality. For South Carolina and other states to develop and put into action statewide prevention plans for older adults, federal support and funding are critical. Public policy changes are needed to redirect the current medical model of health care toward an integrated approach that incorporates disease prevention and health promotion measures. Funding of healthy aging programs should be a Congressional priority. Taking action now would increase the quality and years of life for many older adults and would save substantial health care dollars in the future. With support from Congress, the Centers for Disease Control and Prevention (CDC), in collaboration with the Administration on Aging (AOA), is positioned to take the lead in helping states develop plans for healthy aging and build capacity for sound, scientific-based prevention programs. With additional support, CDC and AOA have the expertise to serve as resources to state aging and public health programs for consultation, training, technical assistance, and replicable, scientific-based prevention programs.

The state of South Carolina must also make prevention a priority, providing legislative support and funding for health promotion and prevention measures to increase healthy years of life.

## References:

National Blueprint: Increasing Physical Activity Among Adults Age 50 and Older, The Robert Wood Johnson Foundation, Princeton, New Jersey.

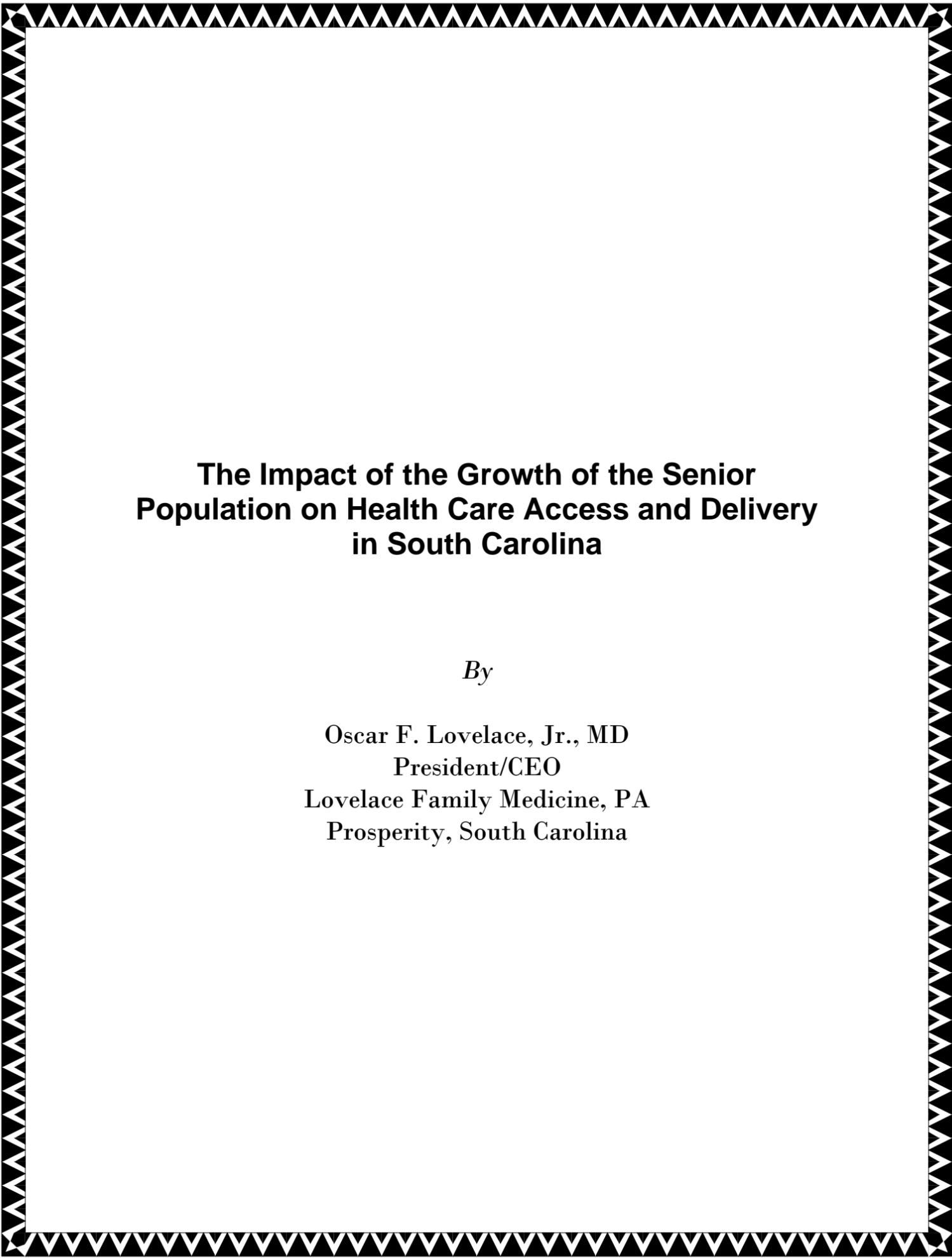
SC DHEC. Bureau of Community Health and Chronic Disease Prevention.

The State of Aging and Health in America 2004, Centers for Disease Control and Prevention and Merck Institute of Aging and Health, Washington, DC.

[www.cdc.gov/aging](http://www.cdc.gov/aging)

[www.cdc.gov/nccdphp](http://www.cdc.gov/nccdphp)

[www.scmatureadults.org](http://www.scmatureadults.org)



**The Impact of the Growth of the Senior  
Population on Health Care Access and Delivery  
in South Carolina**

*By*

Oscar F. Lovelace, Jr., MD  
President/CEO  
Lovelace Family Medicine, PA  
Prosperity, South Carolina

**Issue Statement:** The impact of the growth of the senior population on health care access and delivery in South Carolina.

**Statement**

Many seniors are quick to tell you that a large part of their daily life is spent going to the doctor's office or going to get medicine prescribed by their doctor. While great progress is being made on keeping aging adults independent and enjoying a higher quality of life, both our state and national healthcare delivery system is soon to be overwhelmed by the aging baby boomer generation. Consider the rapid in-migration of seniors to SC; the challenges may well be magnified in SC. At present, SC is the fastest growing state in the Southeast and 5<sup>th</sup> overall for in-migrating seniors in the United States.

The overwhelming responsibility of caring for tomorrow's senior citizens will primarily fall squarely on the shoulders of Medicare (federal government insurance for those >65 and the disabled) and Medicaid (a state/federal program which provides health insurance for the state's poorest citizens).

**Barriers**

There are signs that our current health care delivery system is collapsing under the weight of unreimbursed or under-reimbursed care. The problem is not primarily the fact that the number of uninsured in America is on the rise. No, the current erosion into quality health care is primarily driven by the under-reimbursement for health care services by governmental payers – Medicare and Medicaid. It is expected that by 2014, about 50% of every dollar spent on health care will originate from our governmental payers. Our state and federal legislators, continue to promise preservation if not expansion of the existing Medicaid and Medicare programs to meet the needs of the poor and elderly. Unfortunately, the political promises are often being fulfilled on the backs of nurses, doctors, as well as the facilities committed to care for the elderly.

Fewer physicians are choosing to practice in fields that provide vital services due to escalating malpractice insurance and declining reimbursement. Medicare and Medicaid reimbursement is so low that many physicians are having to limit or close their doors to Medicaid or Medicare patients to keep their own doors open. Many are opting out to practice boutique medicine outside of insurance reimbursement limitations. It is important to remember that even if adequate numbers of physicians have been trained to provide vital primary medical care, unless it is economically viable to perform the service, the service will not be provided. The current delivery system encourages early retirement of more skilled physicians who are having difficulty in finding coworkers willing to provide vital medical care under difficult conditions.

The long-term care industry is presently suffering under the same constraints of low government reimbursement and escalating malpractice insurance cost. Nursing homes have become the new target of the litigation system. The average cost per year

nationwide of insuring an occupied skilled nursing bed has increased from \$240 in 1996 to \$2360 in 2001, and the rate of increase in South Carolina is reported to be even greater. The majority of these costs are borne by the tax-paying public. In addition, state run liability insurance coverage (SC Joint Underwriting Association) is not available to long term care providers in South Carolina. The decreasing number of private liability insurers has caused higher insurance premiums for less coverage.

Federal and state regulations over long-term care have become overwhelming, not only for the long term care providers but also for the physicians caring for patients in these facilities. Federal and state regulations, along with low Medicaid and Medicare reimbursement have led to a system where the most viable alternative for long term care providers is private pay only. Unfortunately, this does not help our most vulnerable, indigent citizens.

Approximately 70% of the state's Medicaid dollars are spent treating the aged, disabled and blind. Our strategic goal should be to allow this population to age in place and avoid expensive out-of-home and institutional care. However, the fact is that 47% of individuals over 85 suffer from dementia and in the future, more families will find long term care the most viable option for appropriate care of their confused loved one.

Currently, every household in South Carolina pays \$485 for tobacco related health care costs every year. This year, a Harvard University study showed that approximately, 40% of US citizens declared bankruptcy because of \$10,000 of medical bills. If you consider that every household puts about \$500 into the tobacco pit every year, by age 40, a citizen would have put about \$10,000 into the tobacco pit; probably, about the time the health care bills might catch up with some families.

### **Workable Solutions**

There is presently a three-year waiting list for students interested in becoming a licensed practical nurse because South Carolina has been unwilling to commit to providing nurse educators for our technical colleges. According to Donald Strunk, economist, from the Darla Moore School of Business, nurses are the health care professionals most needed in a new grayer South Carolina. Recently, The State newspaper series on the nursing shortage in South Carolina pointed out that graduate level nurses need to be recruited out of the private sector to teach nursing students. The article pointed out that nurse educators' annual salaries need to increase by \$10,000-\$20,000 to make teaching nurses competitive with private practice salaries.

Increasing the cigarette tax in South Carolina is the better solution. Recent studies show that the best way to avoid dementia is to care for your heart through healthy living. Vascular disease is the predominant cause of dementia. Cigarette smoking is a major cause of vascular disease. According to the Centers for Disease Control Study, released in May 2002, \$6.52 was spent on tobacco related health care and long-term

disability costs for each pack of cigarettes sold in South Carolina. Most recently, Frank Sloan, economist at Duke University, published a book, THE PRICE OF SMOKING, outlining a more comprehensive analysis of the cost of cigarette smoking in our society. He concludes that every pack is costing society \$40; \$33 for the smoker; \$5 for the smoker's spouse; and \$1.50 for the passive smoker exposed to tobacco smoke. It is understandable that the business community, which is attempting to provide health coverage for their employees, and the healthcare delivery system, which is collapsing under the weight of un-reimbursed care, are in support of shifting this burden to the tobacco user.

### **Recommendation for Action**

A substantial cigarette tax increase could bring in much needed revenue for a faltering healthcare delivery system, decrease adult use (4% for every 10% increase in per pack cost) and teen initiation (7% for every 10% increase in per pack cost), and immediately save tobacco related health care costs. In fact, a person's risk of heart attack and stroke declines within a week of the elimination of smoking. Based on studies from the other 30 states which have passed a cigarette tax increase, simply raising the cigarette tax to \$1.00 in South Carolina would save \$15 million over five years by preventing heart attacks and strokes alone.

The challenges that lie ahead for South Carolina must be addressed at once to avert a societal crisis as our in-migrating and native citizens in the baby boomer generation turn into octogenarians. There is no better solution than a substantial increase in South Carolina's meager seven cents per pack tax on tobacco.



# **Improving the Health of South Carolina's Minority Seniors**

*By*

**Gardenia B. Ruff, MSW**

**Director**

**Office of Minority Health**

**SC Department of Health & Environmental Control**

**Columbia, South Carolina**

## **“IMPROVING THE HEALTH OF SOUTH CAROLINA’S MINORITY SENIORS”**

### **Contact**

Gardenia B. Ruff, M.S.W.  
Director, Office of Minority Health  
South Carolina Department of Health  
and Environmental Control  
2600 Bull Street  
Columbia, South Carolina 29201  
Telephone: (803) 898-3808  
Fax: (803) 898-3810  
Email: [ruffgb@dhec.sc.gov](mailto:ruffgb@dhec.sc.gov)

### **Statement of the Issue**

As a group, African-Americans live sicker and suffer more than other groups from a number of long-term illnesses. Illnesses like cardiovascular disease, including heart disease and stroke, and diabetes are more common in the African-American community. For example, of those 65 and older, African-Americans are *twice* as likely to report having diabetes and *four times* more likely to die from diabetes than Whites. Older African-Americans are also less likely to receive the recommended vaccines against the flu and pneumonia, making them more likely to have complications and die from these conditions. These differences in health status are known as health disparities. Health disparities really point to differences in the burden of disease and illnesses experienced between population groups. Health disparities may be seen as differences in developing a health problem, becoming sick or being hospitalized for a health problem, or death due to a health problem. In addition to poor quality of life, health disparities and poor health among the state’s minority seniors also contribute to rising health care costs and increasing financial obligations at the federal and state levels and for families. South Carolina is working toward eliminating health disparities as a priority. The Department of Health and Environmental Control (DHEC), the state’s leading health agency is committed to improving the health of all South Carolinians through the Healthy People 2010 goals. The two overall goals are: 1) Increase the quality and years of healthy life and 2) Eliminate health disparities. The DHEC Office of Minority Health serves as the agency’s principal advisor on minority health issues.

### **Barriers**

Differences in access, health care and quality, healthcare providers and information contribute to the health disparities among racial and ethnic minorities. A major barrier to eliminating health disparities among minority seniors is access to health care. Access depends on three factors: economic, physical, and cultural. Examples of economic factors are: affordability and inability to pay, either directly or through health insurance. In South Carolina, minorities are more likely to live in poverty than Whites. As minority seniors are more likely to live in poverty and have higher medical costs, these factors put an additional strain on families and may affect medication compliance. Some physical factors are the physical distance from health care services, the hours of operation, number of doctors, and inadequate transportation, especially in rural areas of

South Carolina. Furthermore, the lower quality of healthcare for African-Americans, as documented in the Institute of Medicine report, "Unequal Treatment; Confronting Racial and Ethnic Disparities in Health Care" proves to be an additional barrier to quality health care for many minority seniors. Cultural factors among the senior minority population may also serve as a barrier to health care. There are cultural differences in the values, beliefs, and traditions of African-Americans and other cultural groups. Cultural factors also influence communication between healthcare providers and the senior minority population. Memories of the infamous Tuskegee Experiment and other negative encounters experienced by some minorities may still continue to contribute to a culture of mistrust, especially among minority seniors. A lack of information about availability and eligibility to health care services can also serve as a barrier to access among the senior minority population.

### **Workable Solutions**

Consideration of cultural differences is critical to policy development, planning, and providing health services to the senior minority population. Cultural competence has a significant impact on the quality of health care and service delivery to meet the needs of minority seniors. Cultural competence means understanding and respecting cultural differences. Cultural competence among healthcare providers requires putting behaviors and attitudes into practice to assist in working more effectively with patients of all cultures. Cultural competence training can improve quality of care for minority seniors as health care providers learn to pay special attention to differences in how a disease develops and treatment of disease. Cultural competence training can also contribute to the elimination of health disparities by improving communication between health care providers and senior minority patients. Cultural competence not only addresses language barriers but also involves enhanced understanding and trust of the health care system among minority seniors. Large health institutions should have culturally competent guidelines and policies to support equality of health care and enforce those policies.

Increased number of minorities in the healthcare professions can improve quality of health care and treatment of minority seniors. Through programs that help minorities enter into the health professions, more minority health care providers will be able to practice in minority communities. More programs are needed to recruit, train, and retain minorities in the health care professions. By practicing in medically underserved areas, minority health care professionals can have a significant impact on the health of minority seniors. A diverse and well-trained workforce can improve efforts to reach minority seniors and address health disparities in communities of color.

Partnerships with churches and other community organizations are also needed to eliminate health disparities and improve the health of minority seniors. Just as programs designed for the general population do not meet the needs of the general elder population, programs designed for the general elder population do not meet the needs of the senior minority population. A "one-size-fits-all" approach to designing service programs will not work. By working with churches and other community groups more effective ways can be found to reach minority seniors based on their values, beliefs, and traditions. Such partnerships can strengthen efforts to provide more

culturally appropriate and accessible health care and promote greater understanding of the health needs of minority seniors. These partnerships can also enhance advocacy efforts to support environmental and policy changes for prevention and healthy lifestyles. By combining the resources of diverse partners, improved access to health and social services can be provided to senior minority populations, especially in rural areas of South Carolina.

Lifestyle habits and heredity also impact health disparities. Even though family history of illness can increase the likelihood of developing some conditions, poor health is not an inevitable outcome of aging. Culturally appropriate programs including culturally competent outreach strategies can improve understanding of behavior that increases the risk of developing disease and how to improve quality of life. These programs can also increase the ability of minority seniors to take active roles in their health and health care. Such programs can provide the education and training needed for minority seniors to become informed health consumers. By taking steps to be more physically active and choosing healthier diets, more of South Carolina's minority seniors can enjoy longer, healthier lives.

### **Recommendations**

To overcome barriers to healthcare among the senior minority population, the issues of access and cultural competence need to be addressed.

#### **Access:**

- Greater access to and availability of health care services, especially in rural and medically underserved communities will make a difference in the health status of minority seniors.
- Extended office hours, transportation, and affordability of health care services are needed.
- Healthy lifestyles should be encouraged through community programs and safe places to walk and be physically active should be part of neighborhoods.
- By increasing the number of minority healthcare professionals, especially in rural communities, the senior minority population will have greater access to culturally competent health care services.

#### **Cultural competence:**

- Communities should work together to make sure that policies, programs, and health care services are culturally competent and meet the needs of minority seniors.
- The issues of mistrust and fear should be addressed to encourage more minorities to seek health care before they get sick.
- The participation of more minorities in clinical trials and research are needed to increase understanding of health disparities and provide recommendations for elimination.
- Cultural competence training should be required for all healthcare professionals.



## **Medical Malpractice Caps**

By

Jan L. Warner, BS, JD, LLM  
Attorney at Law  
Warner, Payne & Black, LLP  
ElderLaw Services of SC, PA  
Columbia, South Carolina

## HEALTH CARE ISSUE PAPER – Jan Warner

Medical Malpractice Caps: Necessary or governmental myth to further control the middle class? Should the government place itself in the shoes of the jury which is made up of the same people who elect it without promising reduced health care, prescription drug, and health insurance costs?

Contrary to the governmental pitches and public relations, limiting medical malpractice awards will not lead to successful health care cost containment, but will hurt middle class and lower income families -- especially seniors – who may deserve compensation.

By taking away the threat of medical malpractice suits and limiting damages, the government will take away the incentive to deliver the best health care product possible. Remember Ford Motor Company and the exploding Pinto?

To contain health care costs, the government must reform the manner in which health care services are delivered, not limit compensation for injury and death. For example, although waste runs rampant in our health care system, including high administrative costs, there are no governmental efforts being made to fix it. And while our health insurance premiums continue to skyrocket along with the cost of drugs and medical care, the government blames the debacle on lawyers and medical malpractice claims because lawyers, seniors, and middle class people are easy targets for the current administration.

Caps on lawsuits will hurt already injured patients and their families. Is the government offering you a reduction in your prescription drug bill, your doctor bill, your hospital bill, and your health insurance bill if caps are placed on medical malpractice claims?

You have not, and you will not because caps will not lower doctors' liability insurance rates or your health insurance costs.

As usual, it is the American middle class family and senior against the well-funded lobbyists who are bent on further hurting injured patients and their families. Have you heard any cry by government that doctors' malpractice insurance premiums are too high, and they are finding legitimate ways to reduce medical malpractice premiums by getting the insurance companies to stop gouging the physicians? Of course not, even though it is warranted.

In the State of Washington, for example, Physicians Insurance, the state's largest medical malpractice insurer, was ordered to process refunds of more than \$1.3 million plus interest to nearly 2,400 doctors. The highest refund is more than \$4,600.

Under California's Proposition 103 that requires insurance companies to open their books and justify rate increases, the California Insurance Commissioner in 2003 required that state's second largest malpractice insurance carrier to reduce a proposed 15.6 percent increase to 9.9 percent, saving doctors millions of dollars of additional premiums.

Other states require prior approval by their insurance department before there can be rate increases on medical malpractice policies. How many more malpractice carriers gouge their policyholders? Every time there is a flood, a hurricane, or a 911, insurance rates increase – yours, mine, and doctors' because the insurance companies do not have enough reserves and have not done well in the stock market. So, like the government that raises property taxes or other taxes when it needs money, every time they need more money, insurance companies raise premiums. How many of you have seen your homeowners' or automobile coverage increase even though you did not make a claim? How about your health insurance?

While insurance and medical lobbyists say there is an "explosion" in medical malpractice claims, the rise in claims is nowhere near epidemic proportions, but in the vicinity of five percent per year.

The president, congress, and state legislatures are on a crusade to get rid of "frivolous" lawsuits to compensate the elderly and middle class, leaving them as targets. If you want to talk about "frivolous," look at the trade deficit, sending jobs out of this country, reducing what seniors have been promised, eating up Social Security increases with Part B premiums, and passing tax laws that help the wealthy and the corporate giants, but not seniors. How many of you have saved money because of the dividend tax cut? How many of you even have stock accounts? How many of you will save money if the estate tax is repealed – that is, how many of you and your spouses have more than \$3 million today?

The current governmental environment is bent on protecting insurance companies and corporations from 'frivolous lawsuits' by ordinary citizens, but not protecting ordinary citizens from health, safety, and quality of life problems to which they turn a blind eye.

The same government that paid newspaper columnist Armstrong Williams two hundred and forty thousand dollars of our money to promote the 'No Child Left Behind' initiative is paying plenty to jeopardize seniors' right.

When government has gone from plus \$2.4 Trillion to minus \$5 Trillion deficit on the backs of the middle class and seniors, it has little room to talk about reform until it gets its own house in order.

When government cuts \$22 billion in estate taxes from the wealthiest one percent of the population so it can reduce Medicaid benefits needed by our seniors by \$60 billion, veteran's benefits by \$16 billion, and educational programs so only the wealthy can be educated, it appears they need to get their house in order before they start infiltrating other areas to help big business.

Our court systems weed out bad cases and have the authority to exact sanctions against the lawyers who bring them. This is the way in which to remove non-meritorious claims from the system, not be limiting the compensation a jury can award to victims of malpractice. Even though the cost of caring for disabled child for a lifetime will cost millions of dollars, that is irrelevant. Government wants to cap all awards. That is not fair.

Bottom Line: Every time the government tells us it is going to benefit us, it should be required to show us the economic benefit or reverse what it has done. Rather than legal reform, we need government reform.

Jan L. Warner  
ElderLaw Services of SC, PA  
[janwarner@janwarner.us](mailto:janwarner@janwarner.us)  
803-799-0554

# **Community Forums Report**

**(E)**  
**Health Care**

## **2005 WHITE HOUSE CONFERENCE ON AGING**

### **COMMUNITY FORUMS**

#### ***HEALTH CARE***

**LOCATION OF EVENT: Florence Civic Center – Florence, SC**

**Priority Issue:**

- A) Access to services and affordability
- B) Need to enhance and encourage health lifestyles/disease prevention
- C) Addressing the cost of healthcare premiums and pharmaceutical costs

**Proposed Solution:**

- A) As the wave of Baby Boomers approaches Medicare's eligibility age, it will become increasingly difficult for the federal government to fund this program without passing along more of the costs to consumers. The Medicare program must be strengthened. Over 40 million older and disabled Americans rely on the Medicare program for their health insurance. Across the board, we need to strengthen the traditional fee-for-service Medicare program for those who will continue to rely on it, even as other types of coverage options are expanded.
- B) There are inadequate numbers of qualified service providers in this region, particularly in rural areas. This impacts an older person's choice regarding from which provider they would like to receive services.

**LOCATION OF EVENT – Gaillard Municipal Auditorium – Charleston, SC**

**Priority Issue:**

Healthcare services in the Trident area are limited to seniors because access to care is often unavailable and unaffordable. Healthcare service providers have minimal training in geriatrics and lack incentives to serve older adults.

**Barriers:**

- 1) Limited access to care (i.e., transportation to medical, dental, and/or eye care appointments);
- 2) High cost of prescription drug;
- 3) Lack of knowledge about services and programs; and
- 4) Minimal training of the medical community on aging.

**Proposed Solutions:**

- A) Involve the faith-based community to assist in increasing knowledge about healthcare resources available to seniors and to increase access for medical, dental,

- and/or eye care appointments.
- B) Urge interest groups to advocate for increasing expanded healthcare benefits and providing more money for healthcare services.
  - C) Encourage health professional boards and associations to offer incentives for healthcare providers who receive geriatric training.

**LOCATION OF EVENT: Fennell Elementary School – Yemassee, SC**

**Priority Issue:**

Cost of healthcare premiums and pharmaceutical costs; access/affordability of services; need to enhance/encourage healthy lifestyles/disease prevention; transportation.

**Barriers:**

- 1) Costs of pharmaceuticals out of reach of most seniors on Social Security; new card does not help enough – deductible too high – too complicated to understand;
- 2) There are no limitations and no uniformity in doctors/hospital costs;
- 3) Not enough medical providers nor participating Medicare providers in rural and impoverished areas;
- 4) Levels for Medicaid for seniors too low and do not have realistic guidelines to consider for costs of housing and other expenses related to aging.
- 5) Transportation non-existent/too expensive in rural areas to travel to doctor appointments.

**Proposed Solution(s):**

- 1) States be allowed to bargain for bulk purchasing of pharmaceuticals and/or purchase from Canadian suppliers and pass on savings to seniors.
- 2) Government set profit limits for insurance companies and pharmaceutical companies.
- 3) Government increase Medicaid payment scale for doctors and hospitals to better meet costs of overhead.
- 4) Offer tax and financial incentives to encourage medical providers to work in impoverished and rural areas.
- 5) Re-evaluate Medicaid eligibility limitations to allow for more realistic costs for housing and other living expenses.
- 6) Allow non-Medicaid patients to pay for seat to ride on Medicaid buses to and from doctor appointments.
- 7) Offer more financial incentives to faith-based community to provide mobile units using volunteer drivers in rural areas; provide affordable insurance protection to volunteers in such roles; expand Good Samaritan Law to cover volunteers.

**LOCATION OF EVENT: Capital Senior Center – Columbia, SC**

**Priority Issue:**

Lack of access to services, equipment, prescription medications; insurance gaps and coverage; education – health literacy (awareness, prevention); lack of funding – ways of directing funding, shifting, broader coverage; advance directives.

**Barriers:**

- 1) Not spending enough on aging issues.
- 2) White House Conference on Aging (WHCoA) – every ten years is not enough; discussions not addressing specific issues.
- 3) Education/Communication – “Early” awareness (take away negative re: dying).

**Proposed Solution(s):**

- 1) Develop strategies that encourage and increase insurance carriers including Medicare, to cover previous services and reimburse for a) preventive services and equipment that support previous services; and b) healthy lifestyle behaviors.
- 2) Initiate, at the federal and state levels, a shift from high-tech services to community based low-tech, preventive services.

**LOCATION OF EVENT: Upper Savannah AAA – Greenwood, SC**

**Priority Issue:**

- 1) Access and education of available services;
- 2) Complexity of process for medical care and billing/copay;
- 3) Medication cost, drug cards;
- 4) Cost of insurance/healthcare, cost of medical care and services;
- 5) Need for geriatric doctors;
- 6) Increase funding for Medicare/Medicaid;
- 7) Availability of in-home services.

**Barriers:**

- 1) Transportation, cost, education on what's available, generic vs name brand, reluctance to ask for assistance, sensitivity of doctor in cost of medication.
- 2) Health care is complex, lack of education, and interaction of insurances.
- 3) Understanding what you are buying, lack of coverage, availability of coverage, need to research.
- 4) Complex systems – unable to talk with a person, reluctant to explore services, waiting for a crisis.
- 5) Lack of geriatric doctors, transportation.
- 6) Lack of funding those that fall through the cracks, no insurance.

**Proposed Solution(s):**

- 1) Home delivery of meds (ask for samples from doctor, ask for generic meds).
- 2) Simpler system – assistance from doctors' office with forms, etc.
- 3) Uniformity of products, insurance counseling (I-Care).
- 4) Pre-planning education, one Stop Shop, take information to the seniors/community.
- 5) Find funding for doctor to provide in home care, going to the patient.

6) Pull from churches and communities.

**LOCATION OF EVENT: Pinckney Hall, Sun City Hilton Head – Bluffton, SC**

**Priority Issue:**

Cost of health care premiums and pharmaceutical costs; access and affordability of services; need to encourage/enhance healthy lifestyles and disease prevention.

**Barriers:**

- 1) Prescription drug costs too high even with new drug card due to high deductible and other limitations.
- 2) Medicaid waiver and/or guidelines do not safeguard middle income seniors' assets.
- 3) Medical expenses continue to rise, in part due to high cost of malpractice insurance.
- 4) Excessive incidental charges by hospitals too high, running up billing to insurance companies and consumers.
- 5) Spend down rules exhaust retirees' assets before help from Medicaid.
- 6) Corporations are cutting medical benefits for retirees.
- 7) Drug costs are elevated due in part to advertising costs.
- 8) Caregivers of elderly parents are not protected with parental leave law.
- 9) Medical billings are too complicated and confusing for seniors.
- 10) Shortage of geriatricians prevents adequate health care in rural areas.

**Proposed Solution(s):**

- 1) Outlaw drug advertising in media; and require pharmaceutical companies to pass savings on to consumers; have FCC monitor to ensure compliance.
- 2) Review and increase Medicaid eligibility requirements to better reflect cost of living to serve more seniors.
- 3) Place profit ceiling on medical providers and pharmaceutical companies.
- 4) Have more aggressive monitoring of billing practices of medical providers.
- 5) Review spend down rules to reflect more accurate cost of living for seniors.
- 6) Stop subsidizing tobacco farmers and use the savings to increase funding for senior services.
- 7) Implement Parental Leave Act as part of Older Americans Act to protect caregivers who are caring for frail and elderly senior parents.
- 8) Provide financial support and tax breaks for caregivers of seniors.
- 9) Encourage more geriatric practices in rural areas with tax incentives and student loan waivers.
- 10) Fund more aggressive training for physicians and their staff to help seniors access services and information on diseases.
- 11) Provide more readily available assistance to seniors with medical billing confusion.
- 12) Provide Tort controls to limit malpractice liability; limit cost of malpractice insurance.

**LOCATION OF EVENT: H. Odell Weeks Activity Center – Aiken, SC**

**Priority Issue:**

Seniors, in the primarily rural Lower Savannah Region of South Carolina, have difficulty accessing health care services to maintain or improve their overall health. Very often, medical services are unavailable.

**Barriers:**

- 1) Limited transportation to medical appointments for seniors of all economic levels.
- 2) High cost of prescription drugs and confusion about the prescription drug cards.
- 3) Lack of knowledge about health services and programs.
- 4) Lack of health education for disease prevention/health promotion, and good nutrition.
- 5) Lack of physicians and specialists to meet the demand in rural communities due to high malpractice insurance cost.
- 6) Lack of available assistance to seniors for medication management due to liability concerns.

**Proposed Solution(s):**

- 1) Partnerships with agencies that provide transportation at affordable costs.
- 2) Increase education programs for seniors through agencies and the faith based organizations.
- 3) Increase health promotion/disease prevention education.
- 4) Tort Reform/controls on medical malpractice insurance premiums.
- 5) Increase knowledge and assistance for seniors in need of medication management.
- 6) Increase knowledge to the communities about Medicare Part D and other prescription drug assistance programs that are available.

**LOCATION OF EVENT: Orangeburg County Council on Aging–Orangeburg, SC****Priority Issue:**

Seniors in the primarily rural Lower Savannah Region of South Carolina have difficulty accessing health care services to maintain or improve their overall health. Very often, medical services are unavailable.

**Barriers:**

- 1) Limited transportation to medical appointments of all economic levels.
- 2) High cost of prescription drugs and confusion about the prescription drug cards.
- 3) Lack of knowledge about health services and programs.
- 4) Lack of health education for disease prevention/health promotion, and good nutrition.
- 5) Lack of physicians and specialists to meet the demand in rural communities due to high malpractice insurance cost.
- 6) Lack of available assistance to seniors for medication management due to liability concerns.

**Proposed Solution(s):**

- 1) Partnerships with agencies that provide transportation at affordable costs.

- 2) Increase education programs for seniors through agencies and the faith based organizations.
- 3) Increase health promotion/disease prevention education.
- 4) Tort reform/controls on medical malpractice insurance premiums.
- 5) Increase knowledge and assistance for seniors in need of medication management.
- 6) Increase knowledge to the communities about Medicare Part D and other prescription drug assistance programs that are available.
- 7) Seniors should have the same health care as our Native Americans.

**LOCATION OF EVENT: City Council Chambers – Rock Hill, SC**

**Priority Issue:**

Seniors in the Catawba Region lack access to adequate health care.

**Barriers:**

- 1) Due to the expense of healthcare, doctors do not get to see senior patients until they are often already suffering from an illness.
- 2) Funding for wellness programs for seniors.
- 3) Seniors having to choose between healthcare and eating.
- 4) Medication and drug program changes effective for 2006 are very confusing.
- 5) People (seniors) who need the medicine do not have the power to make the decisions that need to be made.
- 6) Pharmaceutical industry spends more on marketing than they do on research.
- 7) South Carolina fazing out Silver Card at the detriment to seniors.
- 8) Changes to Medicare Program confusing.
- 9) The right to buy medicine cheaper. For example, buying medicine from Canada.
- 10) Changes that are being forced upon states by federal government will devastate seniors.
- 11) Seniors are the fastest growing population.

**Proposed Solution(s):**

- 1) Establish a task force to come up with intervention to deal with issues related to healthcare.
- 2) Need more funding for wellness for seniors.
- 3) Less expensive to provide basic medical care for seniors.
- 4) Competitive bidding process needed in the pharmaceutical industry to drive the cost of medicine down.
- 5) The ability to buy medicine in bulk would save seniors money.
- 6) Senior population should have clout given t heir growth rate and should use that clout.
- 7) We must insure that the senior voices are heard.
- 8) Keeping the caregiver's health is crucial to the care of the senior.
- 9) Networking is the key to being successful in assisting seniors.

**LOCATION OF EVENT: Santee-Lynches Regional Council of Governments –  
Sumter, SC**

**Priority Issue:**

Full range healthcare too expensive for the individual.

**Barriers:**

- 1) Cost of training practitioners/providers.
- 2) More value placed on profit than service.
- 3) Abuse of system drives up costs.
- 4) Laws and complexity of system to access benefits.
- 5) Malpractice insurance.
- 6) Many Medicare/Medicaid payments are not adequate.
- 7) Well or preventive care not usually covered by insurance.

**Proposed Solution(s):**

Offer affordable health insurance that fully covers: medical, dental, vision, hearing, mental health care, and medications.

**LOCATION OF EVENT: Emmanuel Baptist Church – Manning, SC**

**Priority Issue:**

Medicare/Medicaid going broke.

**Barriers:**

- 1) Increased aging population as people are living longer.
- 2) People demanding more services.
- 3) Lack of governmental funding.
- 4) Medicare/Medicaid fraud by providers; absurd charges.
- 5) Paperwork mistakes.

**Proposed Solution(s):**

- 1) More cost share by people who can afford it (perhaps higher premiums or deductibles).
- 2) Increase government funding.
- 3) More auditing of providers.
- 4) Restrict Medicare/Medicaid eligibility to U.S. citizens and those foreigners who are here legally.

**Priority Issue #2:**

Lack of participating providers who accept Medicare/Medicaid patients.

**Barriers:**

- 1) Sufficient allowable charges.

- 2) Inadequate funding.
- 3) Providers giving correct cost data.
- 4) Cost of malpractice insurance keeps prices high and reduces number of available providers.

**Proposed Solution(s):**

- 1) Obtain a realistic assessment of charges to ensure adequate allowable charges.
- 2) Provide incentives for providers.

**Focus Group Concern:** (1) Health programs/education for rural areas; (2) Age discrimination in health care system; (3) Affordable healthcare needed; (4) More preventive education; (5) More medical research needed; and (6) Insufficient geriatric doctors.

**LOCATION OF EVENT: Kershaw County Health Resource Center – Camden, SC**

**Priority Issue #1:**

Affordable medical care for seniors to include medications.

**Barriers:**

- 1) Upfront deductibles too high.
- 2) Inability for many people to understand their options (difficulty of applications).
- 3) Lack of award caps on lawsuits.
- 4) Cost of malpractice insurance for physicians, causing increase in health care costs.

**Proposed Solution(s):**

- 1) Legislation to cap malpractice lawsuits.
- 2) Provide physicians incentives to provide more pro bono medical care.
- 3) Medicare and other insurance companies should allow “monthly” deductibles to make amounts easier to pay.
- 4) If federal government provides funds for medical education, the federal government should make it a requirement for the physician to practice in a rural area for at least a year or two.
- 5) Federal government should provide incentives for physicians to provide care in rural areas (possibly tax breaks).
- 6) County or community should provide incentives for physicians to locate in rural communities (free or low cost housing, office space, etc.)
- 7) Clarify/simplify eligibility and enrollment information so people would readily understand what health care programs are available to them.
- (8) Ensure fair, variable Medicare/Medicaid co-pay amounts, depending on income.

**Priority Issue #2**

Preventive Screening and Education.

**Barriers:**

- 1) Mobile units are available in some areas, but are under used.
- 2) Insufficient geriatric training for physicians/specialists, especially rural areas.
- 3) People don't always know they need to be screened and live a healthy lifestyle to prevent illness/diseases.
- 4) Insurance doesn't always pay for preventive care.
- 5) Not enough promotion of preventive care/health screening.
- 6) Lack of understanding by providers of ways to care for respond to older patients.

**Proposed Solution(s):**

- 1) Make full use of the mobile screening units that are available in the county; ensure they are staffed appropriately and ensure volunteers are readily available to assist.
- 2) Ensure there are ongoing and up-to-date training programs for providers of geriatric care.
- 3) Allow additional preventive screenings (covered by insurance) if referral is made by a doctor.
- 4) Educate physicians/providers in ways to care for/respond to seniors.
- 5) Medicare should pay 100% of an annual preventive screening for all people, not just the newcomers.

**LOCATION OF EVENT: The Shepherd's Center – Sumter, SC**

**Priority Issue:**

Affordable healthcare to include (medications, mental health, screening, vision, hearing, and dental).

**Barriers:**

- 1) Healthcare and health screenings are far too expensive for seniors and those with disabilities.
- 2) Lack of funding.
- 3) Lack of volunteers to assist with mobile screening units and other medical facilities.
- 4) Fraud by healthcare providers, pharmaceutical companies, and insurance companies.
- 5) Seniors need additional education on how to maintain a healthy lifestyle.
- 6) Healthcare providers need to be educated on how to appropriately communicate with senior patients.
- 7) Medical billing is too confusing to understand (errors or overcharges are hard to catch).

**Proposed Solution(s):**

- 1) Expand education program to providers and recipients.
- 2) Stop medication ads on TV.
- 3) Eliminate provider "pay-offs" by drug companies.

- 4) Use mobile screening units, especially in rural areas to ensure early diagnosis of problems.
- 5) Encourage more grass root contacts and involvement to help educate and assist seniors.
- 6) Ensure there are clear and simple instructions for medical billing and enrollment in various healthcare programs.
- 7) Fund additional research to eliminate or delay diseases and disabilities to lessen demand on medical treatment facilities and reduce recipient costs.
- 8) Increase the number of home health providers so seniors can age in place and decrease demand on institutions and medical treatment facilities.

**Focus Group Concern:** Shrinking number of geriatric providers even though the number of seniors are increasing because providers believe they don't get reimbursed sufficiently for Medicare/Medicaid clients.

**LOCATION OF EVENT:** Bethlehem United Methodist Church – Bishopville, SC

**Priority Issue:**

Access to health care including medications.

**Barriers:**

- 1) No health care available in Bishopville area after 5:00 pm weekdays and none on weekends.
- 2) Lack of money.
- 3) Lack of providers (specifically geriatric providers).
- 4) Lack of adequate transportation; what is available is not senior friendly.
- 5) Medication and medical programs too difficult to understand/access.
- 6) Medications too expensive.
- 7) Lack of specialty services to include therapy services.

**Proposed Solution(s):**

- 1) Fund/build a hospital in Bishopville (or at least fund an emergency care facility).
- 2) Provide incentives to attract providers to area by considering: tax breaks, housing, and pay for medical education.
- 3) Provide all required services to include specialties.
- 4) Review medical spending priorities at county and state levels.
- 5) Go to foreign countries to get cheaper medications if needed (creates competition).
- 6) Create an inexpensive, dependable, and senior friendly transportation system.
- 7) Prohibit campaign donations by drug companies.
- 8) Simplify all medical program enrollment forms.

**Focus Group Concern:** (1) Need for preventive health education programs, (2) Increased research needed to eliminate or reduce diseases and disabilities, and (3) Respect for age.